Patient Front Sheet

Today's Date:_____

Children's Information

Last Name, First Name	Sex	Date of Birth	Last Name, First Name	Sex	Date of Birth
_____		___/_____	_____		___/_____
_____		___/_____	_____		___/_____
_____		___/_____	_____		___/_____

Do any of the children have Parent or Guarantor information different from those below? Y / N

Parent's Information

Parent/Guardian (Guarantor) _____ Date of Birth ___/___/_____

Relationship to Patient: _____

Home Address: _____

City: _____ Zip: _____

Home Phone: (_____)_____

Cell: (____)_____

Email: _____

Parent/Guardian _____ Date of Birth ___/___/_____

Relationship to Patient: _____

Home Address: _____

City: _____ Zip: _____

Home Phone: (_____)_____

Cell: (____)_____

Email: _____

Circle 1 Preferred Phone Number and 1 Preferred Email for us to contact in case of questions or emergency.

☐ Check if you do NOT want us to leave voice messages on your preferred number.

☐ Check if you prefer receiving Text appointment reminders. (Speak with staff to opt in; standard messaging fees apply.)

Occupation:_____

Employer: _____

Work Phone: (_____)_____

Occupation:_____

Employer: _____

Work Phone: (_____)_____

Parents' Marital Status: _____

In case of emergency, notify (other than parent):

Name: _____ Phone Number: (_____) _____

Relationship to Patient: _____

Name of Insurance: _____

Who referred you to our practice? _____

Preferred Pharmacy (Name, Street, City) _____

Alan Johnson, M.D Susan B. Dab, M. ! Gary Gin, * ! Michelle Pepitone, M.D.
Tatiana Goldstein, M.D. Kathryn Meier, M.D. Jennifer Wray, ! , Adam R. Davis, M.D.

sfbay pediatrics

San Francisco: 525 Spruce Street, Suite 3, San Francisco, CA 94118 Phone: 415.668.8900 Fax: 415.668.1695

Marin: 591 Redwood Highway, Suite 5215, Mill Valley, CA 94941 Phone: 415.381.5400 Fax: 415.381.9999

PEDIATRIC PATIENT HISTORY

Today's Date:_____

Patient's Name: _____ Date of Birth: _____

Informant (Relationship to patient): _____

Previous Pediatrician: _____ Location: _____

MOTHER'S HISTORY: (circle the appropriate response)

PREGNANCY:

1. Illnesses	☐ NO	☐ YES
2. Drugs	☐ NO	☐ YES
3. Prematurity	☐ NO	☐ YES
4. Hospitalization	☐ NO	☐ YES
5. Bleeding	☐ NO	☐ YES
6. Smoking	☐ NO	☐ YES
7. Drinking	☐ NO	☐ YES

LABOR AND DELIVERY:

9. Cesarean Section	☐ NO	☐ YES
10. Prolonged Labor	☐ NO	☐ YES
11. Complications	☐ NO	☐ YES

NEWBORN STAY:

1. Prolonged Stay	☐ NO	☐ YES
2. Jaundice	☐ NO	☐ YES
3. Other:_____		

Comments on **YES** responses: _____

PATIENT'S HISTORY

1. Allergic to_____		
a. medication	☐ NO	☐ YES
b. other	☐ NO	☐ YES
2. Childhood Illnesses		
b. Ear infections	☐ NO	☐ YES
c. Asthma	☐ NO	☐ YES
d. Frequent colds	☐ NO	☐ YES
e. Stomach problems	☐ NO	☐ YES
f. Other_____		

3. Hospitalizations	☐ NO	☐ YES
4. Surgeries	☐ NO	☐ YES
5. Dental Problems	☐ NO	☐ YES
6. Injuries, Poisonings	☐ NO	☐ YES
8. Vaccine reactions	☐ NO	☐ YES
9. Current medications	☐ NO	☐ YES
10. Vision or hearing problems	☐ NO	☐ YES
11. Daycare/Preschool	☐ NO	☐ YES
12. Learning or developmental problems?	☐ NO	☐ YES

Comments on **YES** responses: _____

_____

FAMILY MEDICAL HISTORY: (includes mom, dad, aunts, uncles, and grandparents)

Are there any immediate family members who have a special medical problem or who are on special medications? ☐**NO** ☐**YES**_____

Are there any immediate family members who have died of medical causes? ☐**NO** ☐**YES**

IF SO, WHO? _____**CAUSE?**_____

Are there any immediate family members who have these conditions? If yes, which members?

Allergies, asthma, eczema	☐NO	☐ YES
High cholesterol or triglycerides	☐NO	☐ YES
Heart Disease	☐NO	☐ YES
High Blood Pressure	☐NO	☐ YES
Endocrine Disorders (Diabetes, thyroid disorder)	☐NO	☐ YES
Anemia, blood disorder, bleeding problems	☐NO	☐ YES
Autoimmune Disease (Lupus, Rheumatoid Arthritis)	☐NO	☐ YES
Tuberculosis, positive skin test	☐NO	☐ YES
Cancer	☐NO	☐ YES
Seizure or convulsion disorder	☐NO	☐ YES
Vision, hearing or speech problems	☐NO	☐ YES
Learning disabilities or developmental delay	☐NO	☐ YES
Birth Defects	☐NO	☐ YES
Domestic Violence	☐NO	☐ YES
Cigarette Use	☐NO	☐ YES
Any psychological or mood disorders, (Depression, anxiety, schizophrenia)	☐NO	☐ YES